

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09240

Reg. Dist. No.

96

9258

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Aikin</b>				d. STREET ADDRESS <b>Aikin</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Samuel</b> First <b>Aikin Sr.</b> Middle Last				4. DATE OF DEATH Month <b>Sept.</b> Day <b>9</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 3, 1870</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Mason</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Henry Clay Aikin</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-12-3461</b>		17. INFORMANT <b>Florence E. Aikin, Perryville, Md. R D</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-Sclerotic</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis</b> DUE TO (c) <b>Arthritis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>8</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug 25, 1956</b> to <b>Sept. 8, 1956</b> , that I last saw the deceased alive on <b>Sept 8, 1956</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clarence I. Benson</b> M.D.				ADDRESS (Street, city or town, state) <b>Port Deposit, Md</b> DATE SIGNED <b>9/10/56</b>			
PHYSICIAN'S NAME (Type) <b>Clarence I. Benson, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-12-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Marks</b>		22d. LOCATION (City, town, or county) (State) <b>Perryville, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. A. Patterson &amp; Son</b> ADDRESS <b>Perryville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>9-11-56</b>		24b. REGISTRAR'S SIGNATURE <b>Irene E. Daugherty</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9247 **CERTIFICATE OF DEATH**

09241

Reg. Dist. No. *92*

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Cecil</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		LENGTH OF STAY (in this place) <i>3 da.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Union Hosp.</i>				STREET ADDRESS (If rural give location) <i>7 Mann Rd. - Elkwood Est.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <i>Charlotte</i> (Middle) <i>Anders</i> (Last) <i>Anders</i>				(Month) <i>Sept.</i> (Day) <i>2</i> (Year) <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct 1, 1923</i>	9. AGE last birthday <i>32</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Baltic Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Noble Blackiston</i>				14. MOTHER'S MAIDEN NAME <i>Esther Platt</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No.</i>		16. SOCIAL SECURITY NO. <i>216-14-9221</i>		17. INFORMANT & ADDRESS <i>Mr. James E. Anders - Elkton</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
171X IMMEDIATE CAUSE (A) <i>Carcinoma of Cervix</i>						INTERVAL BETWEEN ONSET AND DEATH <i>Five months</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Generalized metastasis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19. DATE OF OPERATION <i>June 1956</i>		19b. MAJOR FINDINGS OF OPERATION <i>Gropes - Radium x-ray</i>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <i>June 19, 1956</i> , to <i>Sept 2, 1956</i> , that I last saw the deceased alive on <i>Sept 1, 1956</i> , and that death occurred at <i>745</i> M., from the causes and on the date stated above.							
SIGNATURE <i>One Lord H. Sprecher</i>		DATE THEREOF <i>Sept 5/56</i>		NAME OF CEMETERY OR CREMATORY <i>Wesley Chapel Am.</i>		LOCATION (City, town, or county) (State) <i>Rock Hall, Md.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		24. REC'D BY REGISTRAR <i>IR Trager</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Morris W. Walker</i>		ADDRESS <i>Charleston, Md.</i>	
DATE <i>9/6/56</i>							

CERTIFICATE OF DEATH

Page 1 of 2

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial

18. Signature of interment

19. Signature of cremation

20. Signature of disposition

21. Signature of final disposition

22. Signature of final disposition

23. Signature of final disposition

24. Signature of final disposition

25. Signature of final disposition

26. Signature of final disposition

27. Signature of final disposition

28. Signature of final disposition

29. Signature of final disposition

30. Signature of final disposition

31. Signature of final disposition

32. Signature of final disposition

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41. Signature of final disposition

42. Signature of final disposition

43. Signature of final disposition

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SEP 10 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9248

## CERTIFICATE OF DEATH

09242

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 232 W. Main Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Frank First Middle Last Armstrong				4. DATE OF DEATH Sept 26 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 22 - 1916	
9. AGE (in years last birthday) 40		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant		10b. KIND OF BUSINESS OR INDUSTRY		11. PLACE (State or foreign country) Elkton - Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Harry Armstrong				14. MOTHER'S MAIDEN NAME Georgiana Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216-53-7445		17. INFORMANT Mrs. Elsie Shaw - Sister	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 307X Acute alcoholic insanity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 25, 1956, to Sept 26, 1956, that I last saw the deceased alive on Sept 25, 1956, and that death occurred at 9:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE P. F. McLaughlin M.D.				DATE SIGNED Sept 26, 1956			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 1 1956		22c. NAME OF CEMETERY OR CREMATORY North Crest Md		22d. LOCATION (City, town, or county) (State) North Crest Md	
23. FUNERAL DIRECTOR'S SIGNATURE Harry App				ADDRESS Elkton, Md		24a. REC'D BY REGISTRAR DATE 10/2/56	
						24b. REGISTRAR'S SIGNATURE FR Frazer	



OCT 5 1956

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9259

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,				c. LENGTH OF STAY IN 1b 8yrs. 7mo. 12days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.				47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1806-23rd Street, S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CECIL D. BLANCHARD				4. DATE OF DEATH Month Day Year September 9 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-19-88	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Minnesota	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME David D. Blanchard				14. MOTHER'S MAIDEN NAME Emma G. Merriman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease severe 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial fibrosis with mural thrombus DUE TO (c) Early gangrene left lower extremity 3-4 weeks PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis general, severe unknown 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 28, 1948, to September 9, 1956, and that death occurred at 4:35 PM, from the causes and on the date stated above. ACTIVE AND VISIBLE TO THE REGISTRAR, and that death occurred at 4:35 PM, from the causes and on the date stated above. ACTUAL SIGNATURE W. Oppler M.D. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 9-10-56 PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-10-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE 9-12-56		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

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X  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 14 1956

RECEIVED



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09244

9249

## CERTIFICATE OF DEATH

Reg. Dist. No. 97

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Elkton</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Galena</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>							
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Harper</u> <u>Brice</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Sept. 14</u> <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 28, 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired State road</u>		11. BIRTHPLACE (State or foreign country) <u>Betterton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Brice</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Bramble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Virgie Brice Galena Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
517x IMMEDIATE CAUSE (A) <u>Broncho pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 days.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>aspiration</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Paralysis of throat</u>						<u>6 mos.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Arteriosclerosis</u>						<u>6 years.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 8, 1956</u> to <u>Sept 14, 1956</u> , that I last saw the deceased alive on <u>Sept 14, 1956</u> , and that death occurred at <u>11:57</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Wallace Ohryman</u>				ADDRESS (Street, city, town, state) <u>Cecil, Md.</u>			
DATE <u>Sept 17/1956</u>				DATE SIGNED <u>15 Sept 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 17/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Galena Cem.</u>		LOCATION (City, town, or county) (State) <u>Galena Md.</u>	
24. REC'D BY REGISTRAR <u>SEP 20 1956</u>		REGISTRAR'S SIGNATURE <u>L. R. Luzzo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Wallace Millington</u>		ADDRESS <u>Md.</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Form No. 100

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX (Male or Female)

3. AGE (Years, months, days)

4. DATE OF BIRTH (Month, day, year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (If any)

7. MARITAL STATUS (Single, Married, Widowed, Divorced)

8. DATE OF DEATH (Month, day, year)

9. TIME OF DEATH (Hour, minute)

10. PLACE OF DEATH (City, State, Country)

11. CAUSE OF DEATH (Immediate cause)

12. MEDICAL EXAMINATION (If any)

13. SIGNATURE OF PHYSICIAN (If any)

14. SIGNATURE OF REGISTRAR (If any)

15. SIGNATURE OF WITNESSES (If any)

16. SIGNATURE OF DECEASED (If any)

17. SIGNATURE OF NEXT OF KIN (If any)

18. SIGNATURE OF CLERGYMAN (If any)

19. SIGNATURE OF BURIAL OFFICIAL (If any)

20. SIGNATURE OF OTHER (If any)

BUREAU V. S.

SEP 20 1956

RECEIVED

EMORTUITZMAN

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 9250 CERTIFICATE OF DEATH

09245

Reg. Dist. No. 92

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY Cecil		MARYLAND		STATE Md.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 21 TOWN Elkton		LENGTH OF STAY (in this place) 6 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton		21	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 100 236 E. High St.,				STREET ADDRESS (If rural give location) 236 E. High St.			
<b>3. NAME OF DECEASED</b> (First) Levi (Middle) (Last) Carroll				<b>4. DATE OF DEATH</b> (Month) Sept (Day) 4 (Year) 1956			
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Dec. 4, 1875	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Special Clerk		10b. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) Marion Station, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Levi Carroll				14. MOTHER'S MAIDEN NAME Ida-? Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 181-20-4855 A		17. INFORMANT & ADDRESS Hattie J. Carroll-236 E. High St.			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
592X IMMEDIATE CAUSE (A) Chronic Interstitial Nephritis						INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
ANTECEDENT CAUSE(S) DUE TO (B) Hypotension						6 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Aortic Insufficiency						6 yrs	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept, 19 20, to Sept, 19 1956, that I last saw the deceased alive on Sept 4, 19 56, and that death occurred at 9:54 A.M. from the causes and on the date stated above.							
SIGNATURE James L. Johnson				ADDRESS (Street, city, town, state) 245 E. High St. Elkton, Md.		DATE SIGNED 9/5/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/8/56		NAME OF CEMETERY OR CREMATORY Providence Cemetery		LOCATION (City, town, or county) (State) Elkton, Maryland	
24. REC'D BY REGISTRAR DATE 9/8/56		REGISTRAR'S SIGNATURE J. R. Trager		25. FUNERAL DIRECTOR'S SIGNATURE John P. Bell		ADDRESS 909 Poplar St., Wilm. Del.	

# DEATH CERTIFICATE

1. DECEASED'S NAME (LAST, FIRST, MIDDLE)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. DATE OF REGISTRATION

BUREAU V. S.

SEP 11 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9260 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09246

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Calvert</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princetown</u> c. LENGTH OF STAY IN lb <u>30 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>no</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princetown</u> d. STREET ADDRESS <u>Rt. 7</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Theodore</u> Middle <u>Cook</u> Last <u>Cook</u>				<b>4. DATE OF DEATH</b> Month <u>9</u> Day <u>1</u> Year <u>1956</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6/24/1900</u>	
<b>9. AGE</b> (In years last birthday) <u>56</u> yrs.		<b>10. UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Labour</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Newnan, Ga.</u>	
<b>13. FATHER'S NAME</b> <u>John Cook</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown</u>				<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>			
<b>17. INFORMANT</b> <u>John Vinton</u>				<b>18. ADDRESS</b> <u>1219 E. Federal St. Balto. Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary</u> <u>1120.1</u> DUE TO <u>Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a. m. _____ p. m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>R C Dodson</u>				<b>DATE SIGNED</b> <u>9-1-56</u>			
<b>EXAMINER'S NAME</b> (Type) <u>R C Dodson</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, OR REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>9/6/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Johns</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Baltimore</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Thurston &amp; Co. Harold Chase, Md.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>9/3/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Irene E. Dougherty</u>	



2. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**BUREAU**

SEP 5 1956

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG204 9-24-56 et

# CERTIFICATE OF DEATH

09247

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 405 Park Place		d. STREET ADDRESS 405 Park Place	
3. NAME OF DECEASED (Type or print) John Miller Davis		4. DATE OF DEATH September 14 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1904
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Davis		14. MOTHER'S MAIDEN NAME Ada Steele	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-01-2155	
17. INFORMANT Robert M. Davis		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic myocarditis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 45 to 9/14, 19 56, that I last saw the deceased alive on 9/11, 19 56, and that death occurred at 6 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Herbert Bates		ADDRESS (Street, city or town, state) Elkton Md	
PHYSICIAN'S NAME (Type) J. HERBERT BATES		DATE SIGNED 9/14/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 17, 1956	22c. NAME OF CEMETERY OR CREMATORY Elkton	22d. LOCATION (City, town, or county) (State) Elkton Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Henry Piggus		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR DATE 9/18/56		24b. REGISTRAR'S SIGNATURE J. P. Frazer	

# CERTIFICATE OF DEATH

BUREAU V. S.

SEP 20 1956

RECEIVED

09248

9261

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cecilton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cecilton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>DIXON</u> Last		4. DATE OF DEATH Month <u>Sept</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Labor</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Dixon</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Anna Dixon Cecilton md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 min</u>  <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 10</u> , 19 <u>56</u> , to <u>8 Sep</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8 Sep</u> , 19 <u>56</u> , and that death occurred at <u>9:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Wallace Obenshain M.D.</u>		Cecilton, Md. <u>11 Sep 56</u>	
PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept 11 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Salina Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Villour Millington md.</u>		24a. REC'D BY REGISTRAR DATE <u>11 3 1956</u>	
ADDRESS <u>Millington md.</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Ralph Rues</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

SEP 13 1956

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09249

Reg. Dist. No. 99

9262

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Delaware</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton Rural</b>		c. LENGTH OF STAY IN 1b <b>Visit</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dennis</b> Middle <b>Evans</b> Last <b>Evans</b>		4. DATE OF DEATH Month <b>9</b> Day <b>16</b> Year <b>19 56</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26 1944</b>
9. AGE (In years last birthday) <b>12</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Warren Evans</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Virginia Hayes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>J. Nelson, Media, Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decapitation of head, Compound fracture rt l. leg</b> DUE TO <b>fracture of lower left leg and Drowned</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>850x</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was thrown from boat into the water and hit by Propeller</b>	
20c. TIME OF INJURY Month, Day, Year <b>10-25-56 9-16-56 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Elk River</b>		20f. (City or town) <b>Elkton, R.D. Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9-16-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 19, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Media</b>		22d. LOCATION (City, town, or county) <b>Media, Delaware Co., Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Shaw</b>		ADDRESS <b>North East, Maryland</b>	
24a. REC'D BY REGISTRAR <b>Sept 18 56</b>		24b. REGISTRAR'S SIGNATURE <b>Sarah E. Kothermal</b>	

MEDICAL CERTIFICATION

2

2125

DATE OF DEATH  
1956

DECEASED

REPORT MADE BY

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

CAUSE

PLACE

AGE

SEX

1

DATE OF DEATH

TIME

PLACE

DATE OF DEATH

REPORT MADE BY

REPORT MADE BY

REPORT MADE BY

1

DATE OF DEATH

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BUREAU V. 31

SEP 21 1956

RECEIVED

9263

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b 30yrs. 9mo.				d. STREET ADDRESS 112 Lincoln Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MERRILL Middle H. Last GODFREY				4. DATE OF DEATH Month September Day 18 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-30-94	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry J. Godfrey		14. MOTHER'S MAIDEN NAME Dora Fooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. unknown		17. INFORMATION FROM MR. WELTON GODFREY (Beatrice) Salisbury, Md. Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary embolus, left descending branch, due DUE TO to coronary arteriosclerosis, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Esophagogastroplasty, healing 9-12-56 (Operation for stricture)							INTERVAL BETWEEN ONSET AND DEATH Less than 1 hour unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 3, 1925, to Sept. 18, 1956, and that death occurred at 7:30 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph Rasker M.D.				ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.		DATE SIGNED 9-18-56	
PHYSICIAN'S NAME (Type) J. C. GRASBERGER				Acting Director, Professional Services			
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 9-20-56		22c. NAME OF CEMETERY OR CREMATORY Parsons		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hollaway Funeral Home, 418 E. Church St., Md.				24a. REC'D BY REGISTRAR DATE SEP 21 1956		24b. REGISTRAR'S SIGNATURE Gene Daugherty	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1111, 1200, 1300, 1400, 1500, 1600, 1700, 1800, 1900, 2000, 2100, 2200, 2300, 2400, 2500, 2600, 2700, 2800, 2900, 3000, 3100, 3200, 3300, 3400, 3500, 3600, 3700, 3800, 3900, 4000, 4100, 4200, 4300, 4400, 4500, 4600, 4700, 4800, 4900, 5000, 5100, 5200, 5300, 5400, 5500, 5600, 5700, 5800, 5900, 6000, 6100, 6200, 6300, 6400, 6500, 6600, 6700, 6800, 6900, 7000, 7100, 7200, 7300, 7400, 7500, 7600, 7700, 7800, 7900, 8000, 8100, 8200, 8300, 8400, 8500, 8600, 8700, 8800, 8900, 9000, 9100, 9200, 9300, 9400, 9500, 9600, 9700, 9800, 9900, 10000, 10100, 10200, 10300, 10400, 10500, 10600, 10700, 10800, 10900, 11000, 11100, 11200, 11300, 11400, 11500, 11600, 11700, 11800, 11900, 12000, 12100, 12200, 12300, 12400, 12500, 12600, 12700, 12800, 12900, 13000, 13100, 13200, 13300, 13400, 13500, 13600, 13700, 13800, 13900, 14000, 14100, 14200, 14300, 14400, 14500, 14600, 14700, 14800, 14900, 15000, 15100, 15200, 15300, 15400, 15500, 15600, 15700, 15800, 15900, 16000, 16100, 16200, 16300, 16400, 16500, 16600, 16700, 16800, 16900, 17000, 17100, 17200, 17300, 17400, 17500, 17600, 17700, 17800, 17900, 18000, 18100, 18200, 18300, 18400, 18500, 18600, 18700, 18800, 18900, 19000, 19100, 19200, 19300, 19400, 19500, 19600, 19700, 19800, 19900, 20000, 20100, 20200, 20300, 20400, 20500, 20600, 20700, 20800, 20900, 21000, 21100, 21200, 21300, 21400, 21500, 21600, 21700, 21800, 21900, 22000, 22100, 22200, 22300, 22400, 22500, 22600, 22700, 22800, 22900, 23000, 23100, 23200, 23300, 23400, 23500, 23600, 23700, 23800, 23900, 24000, 24100, 24200, 24300, 24400, 24500, 24600, 24700, 24800, 24900, 25000, 25100, 25200, 25300, 25400, 25500, 25600, 25700, 25800, 25900, 26000, 26100, 26200, 26300, 26400, 26500, 26600, 26700, 26800, 26900, 27000, 27100, 27200, 27300, 27400, 27500, 27600, 27700, 27800, 27900, 28000, 28100, 28200, 28300, 28400, 28500, 28600, 28700, 28800, 28900, 29000, 29100, 29200, 29300, 29400, 29500, 29600, 29700, 29800, 29900, 30000, 30100, 30200, 30300, 30400, 30500, 30600, 30700, 30800, 30900, 31000, 31100, 31200, 31300, 31400, 31500, 31600, 31700, 31800, 31900, 32000, 32100, 32200, 32300, 32400, 32500, 32600, 32700, 32800, 32900, 33000, 33100, 33200, 33300, 33400, 33500, 33600, 33700, 33800, 33900, 34000, 34100, 34200, 34300, 34400, 34500, 34600, 34700, 34800, 34900, 35000, 35100, 35200, 35300, 35400, 35500, 35600, 35700, 35800, 35900, 36000, 36100, 36200, 36300, 36400, 36500, 36600, 36700, 36800, 36900, 37000, 37100, 37200, 37300, 37400, 37500, 37600, 37700, 37800, 37900, 38000, 38100, 38200, 38300, 38400, 38500, 38600, 38700, 38800, 38900, 39000, 39100, 39200, 39300, 39400, 39500, 39600, 39700, 39800, 39900, 40000, 40100, 40200, 40300, 40400, 40500, 40600, 40700, 40800, 40900, 41000, 41100, 41200, 41300, 41400, 41500, 41600, 41700, 41800, 41900, 42000, 42100, 42200, 42300, 42400, 42500, 42600, 42700, 42800, 42900, 43000, 43100, 43200, 43300, 43400, 43500, 43600, 43700, 43800, 43900, 44000, 44100, 44200, 44300, 44400, 44500, 44600, 44700, 44800, 44900, 45000, 45100, 45200, 45300, 45400, 45500, 45600, 45700, 45800, 45900, 46000, 46100, 46200, 46300, 46400, 46500, 46600, 46700, 46800, 46900, 47000, 47100, 47200, 47300, 47400, 47500, 47600, 47700, 47800, 47900, 48000, 48100, 48200, 48300, 48400, 48500, 48600, 48700, 48800, 48900, 49000, 49100, 49200, 49300, 49400, 49500, 49600, 49700, 49800, 49900, 50000, 50100, 50200, 50300, 50400, 50500, 50600, 50700, 50800, 50900, 51000, 51100, 51200, 51300, 51400, 51500, 51600, 51700, 51800, 51900, 52000, 52100, 52200, 52300, 52400, 52500, 52600, 52700, 52800, 52900, 53000, 53100, 53200, 53300, 53400, 53500, 53600, 53700, 53800, 53900, 54000, 54100, 54200, 54300, 54400, 54500, 54600, 54700, 54800, 54900, 55000, 55100, 55200, 55300, 55400, 55500, 55600, 55700, 55800, 55900, 56000, 56100, 56200, 56300, 56400, 56500, 56600, 56700, 56800, 56900, 57000, 57100, 57200, 57300, 57400, 57500, 57600, 57700, 57800, 57900, 58000, 58100, 58200, 58300, 58400, 58500, 58600, 58700, 58800, 58900, 59000, 59100, 59200, 59300, 59400, 59500, 59600, 59700, 59800, 59900, 60000, 60100, 60200, 60300, 60400, 60500, 60600, 60700, 6080

BUREAU  
V. T.

SEP 21 1956

RECEIVED

[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9252 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09251

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>65 Union Hospital</u>			d. STREET ADDRESS <u>Dogwood Road.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Granville</u> Last <u>Gray, Jr.</u>			4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1956</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1954</u>		9. AGE (In years last birthday) <u>1</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Elkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Joseph Granville Gray, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Lillian May Hagan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>                    </u>	17. INFORMANT <u>Joseph G. Gray, Sr. Elkton, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowned</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>929.0</u> (c) <u>                    </u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell into a well hole in next door yard.</u>			
20c. TIME OF INJURY Hour <u>3:55</u> o. m. <u>9-18-56</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Neighbor yard</u>	
		20f. (City or town) <u>Elkton, R.D.</u>		(County) <u>Cecil</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>R. C. Dodson</u>			DATE SIGNED <u>9-19-56</u>		
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Patterningham Cem</u>	
		22d. LOCATION (City, town, or county) <u>Colora. Bul Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson Rising Sun, Md.</u>			24a. REC'D BY REGISTRAR <u>                    </u>		24b. REGISTRAR'S SIGNATURE <u>                    </u>



BUREAU V. S.

SEP 25 1956

RECEIVED

*[Faint handwritten notes at bottom:]*

(1) ...  
... ..

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10199

## 9253 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY <u>Newcastle</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Elkton</u>		LENGTH OF STAY (in this place) <u>9 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Edgemore Gardens, Wilmington, Del.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>				STREET ADDRESS <u>5 North Common Drive</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u>		(Middle) <u>Henry</u>		(Last) <u>Handlin</u>		(Month) <u>Sept</u> (Day) <u>1</u> (Year) <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 17, 1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>
13. FATHER'S NAME <u>John Handlin</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mabel Handlin - wife</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Cerebral embolism and thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial infarction</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic heart disease and coronary occlusion</u>						<u>4 mos</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 24</u> , 19 <u>56</u> , to <u>Sept 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 1</u> , 19 <u>56</u> , and that death occurred at <u>8:45a</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Wallace Blenshain</u>				M.D. <u>Cecilton, Md</u>		DATE SIGNED <u>1 Sept 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-5-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		LOCATION (City, town, or county) <u>Wilmington, Del</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles D. Bishop</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. K. Phipps</u>		ADDRESS <u>Cecilton, Md</u>	
DATE <u>SEP 5 - 1958</u>							

MASSACHUSETTS DEPARTMENT OF PUBLIC SAFETY

BUREAU V. S.

NOV 1 1956

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 94

Items

2, 8:G204 10-2-56:L

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>9264</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton Rural</b> c. LENGTH OF STAY IN 1b <b>Visited</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Delaware</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clifton Heights</b> d. STREET ADDRESS <b>5313 Delmar Rd.</b> <b>2613 Dermin Drive, Maplewood Drive Pk.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Martin</b> Last <b>Hayes</b>		4. DATE OF DEATH Month <b>9</b> Day <b>16</b> Year <b>19 56</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-28-1923</b>
9. AGE (In years last birthday) <b>33</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Concrete Construt ion</b>	
11. BIRTHPLACE (State or foreign country) <b>Wildwood N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Edward W. Hayes, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Florence May Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>N.W.2.</b>	
17. INFORMANT <b>J. Nelson Rigby, Media, Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowned</b> 9298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Jumped into the Elk River to save his nephew</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>10:30 a. m. 9 16 19 56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Elk River</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Elkton P.D.</b>		20f. (City or town) (County) (State) <b>Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R. C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 19, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Media</b>		22d. LOCATION (City, town, or county) (State) <b>Media, Delaware Co., Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>		ADDRESS <b>North East, Maryland</b>	
24a. REC'D BY REGISTRAR <b>Left 18-56</b>		24b. REGISTRAR'S SIGNATURE <b>Sarah E. Roth</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the coroner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS & CERTIFICATE OF DEATH

BUREAU V. S.

SEP 21 1956

RECEIVED



9265

## CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bainbridge, Maryland</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital, Bainbridge, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Linda</b> Middle <b>Sue</b> Last <b>Hough</b>				4. DATE OF DEATH Month <b>September</b> Day <b>24</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>23 September 1956</b>	
9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>56</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) <b>U. S. Naval Hospital Bainbridge, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Thomas Joseph Hough</b>				14. MOTHER'S MAIDEN NAME <b>Billie Louise Meek</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Thomas Joseph Hough, PHA Trailer #93, Village</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis, Congenital</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>9-23</b> , 19 <b>56</b> , to <b>9-24</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9-24</b> , 19 <b>56</b> , and that death occurred at <b>5:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Gerard Cicalese</b>				M.D. <b>U. S. Naval Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Gerard T. Cicalese</b>				<b>Bainbridge, Maryland 25 September 1956</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>26 Sept. 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham</b>		22d. LOCATION (City, town, or county) (State) <b>Colora, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. A. Patterson &amp; Son, Perryville, Md.</b>				24a. REC'D BY REGISTRAR <b>9-25-56</b>		24b. REGISTRAR'S SIGNATURE <b>Willis W. Kelly</b>	

2051243XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

305

LOCALITY		COUNTY		STATE	
BALTIMORE		BALTIMORE		MARYLAND	
DECEASED		SEX		AGE	
JOHN		MALE		25	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
SEP 25 1956		BALTIMORE		HEART DISEASE	
TIME OF DEATH		OCCUPATION		EDUCATION	
10:00 PM		LABORER		HIGH SCHOOL	
MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
NATURAL		12345		YES	
SUICIDE				NO	
ACCIDENT				NO	
HOMICIDE				NO	
OTHER				NO	
SIGNATURE		DATE		PLACE	
J. V. BUREAU		SEP 27 1956		BALTIMORE	

BUREAU V. B.

SEP 27 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09254

9254

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>		LENGTH OF STAY (in this place) <u>5 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deane's Home - nursing home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Thary Annelis Jackson</u>				4. DATE OF DEATH (Month) <u>Sept</u> (Day) <u>25</u> (Year) <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Aug 25 - 1883</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor's nursing</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>73</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Jackson</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME <u>Jessie Campbell</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Wm. Jackson - Port Deposit</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422. IMMEDIATE CAUSE (A) <u>Chronic myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>about 6 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>General arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 25, 1956</u> to <u>Sept 25, 1956</u> that I last saw the deceased alive on <u>Sept 25, 1956</u> and that death occurred at <u>Port Deposit, Md</u> from the causes and on the date stated above.							
SIGNATURE <u>H. A. McNulty</u> M.D.				DATE SIGNED <u>Sept 25, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-30-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		LOCATION (City, town, or county) (State) <u>Port Deposit Md Rural</u>	
24. REC'D BY REGISTRAR <u>9/28/56</u>		REGISTRAR'S SIGNATURE <u>J R Frazer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Patterson</u>		ADDRESS <u>Port Deposit Md</u>	

# CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1956

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. S.

OCT 2 1956

RECEIVED

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RECEIVED  
BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9266

## CERTIFICATE OF DEATH

09255

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Principio Furnace</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Norman</b> Middle <b>Munson</b> Last <b>Jackson</b>				4. DATE OF DEATH Month <b>9</b> Day <b>24</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-2-1881</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Store</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eli C. Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Mary Belle Whitelock</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-32-5912</b>		17. INFORMANT Address <b>Mrs Howard McGuirk, Principio Furnace, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis -</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>Sept 20, 1955</b> , to <b>Sept 24, 1956</b> , that I last saw the deceased alive on <b>Sept 22, 1956</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clarence I. Benson</b> M.D.				ADDRESS (Street, city or town, state) <b>Port Deposit, Md.</b> DATE SIGNED <b>9-25-56</b>			
PHYSICIAN'S NAME (Type) <b>Clarence I. Benson, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-27-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Principio</b>		22d. LOCATION (City, town, or county) (State) <b>Principio Furnace, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>				ADDRESS <b>Perryville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>9-26-1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Isabel E. Langhorne</b>			





1  
Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9267

## CERTIFICATE OF DEATH

Reg. Dist. No.

09256

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>2 mo. 26 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>			d. STREET ADDRESS <b>12x-2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>W.</b> Last <b>JOHNSON</b>			4. DATE OF DEATH Month <b>September</b> Day <b>25</b> Year <b>19 56</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-5-92</b>		9. AGE (In years last birthday) <b>63</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>George Johnson</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>			17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial fibrosis, severe</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis, severe</b> (c) <b>Cardiac hypertrophy</b>					INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, general, severe</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>1</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 30</b> , 19 <b>56</b> , to <b>September 25</b> , 19 <b>56</b> , and that death occurred at <b>2:40 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>9-25-56</b>					
ACTUAL SIGNATURE <b>W. Oppler</b>		PHYSICIAN'S NAME (Type) <b>W. OPPLER</b> <b>Director, Professional Services</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>9-25-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Chestnut Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Rocks, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>			ADDRESS <b>Frederick, Md.</b>		
24a. REC'D BY REGISTRAR DATE <b>9-26-56</b>		24b. REGISTRAR'S SIGNATURE <b>Gene E. Longfellow</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. JOHNSON		AGE 45		SEX Male		RACE White	
DATE OF DEATH SEP 27 1956		PLACE OF DEATH Home		CITY Boston		COUNTY Suffolk	
OCCUPATION None		EDUCATION None		MARRIAGE None		RELIGION None	
CAUSE OF DEATH Myocardial infarction, severe		MANNER OF DEATH Natural		PLACE OF BURIAL None		CITY None	
DATE OF BURIAL None		PLACE OF BURIAL None		CITY None		COUNTY None	
SIGNATURE OF PHYSICIAN None		SIGNATURE OF REGISTRAR None		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None	
DATE OF SIGNATURE None		DATE OF SIGNATURE None		DATE OF SIGNATURE None		DATE OF SIGNATURE None	

BUREAU V. B.

SEP 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9268  
CERTIFICATE OF DEATH

09257

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge, Maryland		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge Village Bainbridge, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bainbridge, Md.			d. STREET ADDRESS Bldg. 921, Apt. 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Richard Middle Owen Last Lazarus			4. DATE OF DEATH Month September Day 21 Year 19 56		
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 September 1956		9. AGE (In years lost birthday) yrs. 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) U. S. Naval Hospital Bainbridge, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Marston (n) Lazarus			14. MOTHER'S MAIDEN NAME Maxine Susan Eisenberg		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Marston Lazarus, Bldg. 921, Apt. 7, Bainbridge Village	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kernicterus 770.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Erythroblastosis Fetalis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from, 9-17, 19 56, to, 9-21, 19 56, that I last saw the deceased alive on 9-21, 19 56, and that death occurred at 0715 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Albert J. Bisese		M.D. U. S. Naval Hospital			
PHYSICIAN'S NAME (Type) Albert J. Bisese		Bainbridge, Maryland 21 September 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF GEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial	9-22-1956	West Nottingham		Coloma, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Leola Patterson & Son, Perryville, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 9/21/1956	24b. REGISTRAR'S SIGNATURE Sheila M. Kelly

# CERTIFICATE OF DEATH

2022

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 10

BUREAU V. S.

SEP 25 1956

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9269**  
**CERTIFICATE OF DEATH**

092587  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frenchtown</b>				d. STREET ADDRESS <b>Frenchtown</b>			
3. NAME OF DECEASED (Type or print) First <b>Clifton</b> Middle <b>Linton</b> Last <b>Linton</b>				4. DATE OF DEATH Month <b>9</b> Day <b>15</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 25, 1909</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>15</b> Hours <b>19</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Black Smith</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Aberdeen P. Ground.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Joseph Linton</b>				14. MOTHER'S MAIDEN NAME <b>Mary Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-10-1995</b>			
17. INFORMANT <b>Mrs Mattie Linton, Perryville, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Angine Pectoris</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>20 minutes</b>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. 11.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>Jan. 9-14, 1956</b> to <b>9-15, 1956</b> , that I last saw the deceased alive on <b>9-14, 1956</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G.H. Richards Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Port Deposit, Md.</b> DATE SIGNED <b>9-15-56</b>			
PHYSICIAN'S NAME (Type) <b>G.H. Richards Jr. M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-18-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. A. Patterson, Jr.</b>				ADDRESS <b>Perryville, Md.</b>			
24a. REC'D BY REGISTRAR DATE <b>9-17-1956</b>		24b. REGISTRAR'S SIGNATURE <b>Jane E. Dougherty</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

SEP 19 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09259

Reg. Dist. No.

96

9270

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit. R.D.</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Claud</b> Middle <b>Robert</b> Last <b>Moran</b>				4. DATE OF DEATH Month <b>9</b> Day <b>24</b> Year <b>1956</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-16-51</b>		9. AGE (In years last birthday) <b>5</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Port Deposit. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Moran</b>				14. MOTHER'S MAIDEN NAME <b>Arminia Vandyle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>James Moran, Port Deposit. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal injuries crushed abdomen.</b>                          822x DUE TO                          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                          (b) _____                          DUE TO                          (c) _____                     </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile turned over and threw him out under car.</b>					
20c. TIME OF INJURY Month, Day, Year <b>8:30 a.m. 9 24 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Shored Road</b>		20f. (City or town) (County) (State) <b>Port Deposit Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R. C. Dodson</b>				DATE SIGNED <b>9-24-56</b>			
EXAMINER'S NAME (Type) <b>R. C. Dodson</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-26-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. A. Patterson &amp; Son</b>				ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>9-26-1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Gene E. Daugherty</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WYOMING STATE DEPARTMENT OF HEALTH - BILLINGHAM 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 27 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9271

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>		c. LENGTH OF STAY in 1b <b>All life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>		d. STREET ADDRESS <b>23 High St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>23 High St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Moran</b>				4. DATE OF DEATH Month Day Year <b>9 25 19 56</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-27-1878</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>All forms of work</b>		11. BIRTHPLACE (State or foreign country) <b>Port Deposit, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Moran</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Banon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-017993</b>		17. INFORMANT <b>Alice Charsha, Port Deposit, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R. C. Dodson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R. C. Dodson</b>				DATE SIGNED <b>9-26-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-28-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>				ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR <b>9-27-1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Inez E. Langherty</b>			



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

327E

BUREAU V. 5

SEP 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09261

9272

## CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge				c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Holloway Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bainbridge, Md.				d. STREET ADDRESS Charlestown, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eunice Mary NEFF				4. DATE OF DEATH Month Day Year September 8 1956			
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 November 1917 38 yrs.		9. AGE (In years lost birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Willoughby Beal				14. MOTHER'S MAIDEN NAME Mattie Kinsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 263-097865		17. INFORMANT Robert J. Neff (husband)		Address Holloway Beach Charlestown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>3 September, 1956</u> , to <u>8 September, 1956</u> , that I last saw the deceased alive on <u>8 September, 1956</u> , and that death occurred at <u>1:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8 September 1956							
ACTUAL SIGNATURE George E. Scott				M.D. _____			
PHYSICIAN'S NAME (Type) George E. Scott, LT MC USNR				U. S. Naval Hospital, Bainbridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal & Burial		10 Sept. 1956		Cedar Grove Cemetery		Pensacola, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
Vee A. Patterson & Son				Perryville, Md.		DATE 8 Sept 56	
						24b. REGISTRAR'S SIGNATURE	
						Shirley A. Kelly	

BUREAU V. 3

SEP 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09262

9273

## CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bainbridge, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit (Manor Heights)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital Bainbridge, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Duard</b> Last <b>Pearson, Jr.</b>				4. DATE OF DEATH Month <b>September</b> Day <b>10</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sep 9, 1956</b>	
9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>		IF UNDER 24 HRS. yrs. <b>1</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -- -- --				10b. KIND OF BUSINESS OR INDUSTRY -- -- --			
11. BIRTHPLACE (State or foreign country) <b>U. S. Naval Hospital Bainbridge, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Herbert Duard Pearson</b>				14. MOTHER'S MAIDEN NAME <b>Mary Sophie Martinez</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -- -- --			
17. INFORMANT <b>Herbert D. Pearson, 107 A Preston Drive,</b>				Address <b>Port Deposit (Manor Heights)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyaline Membrane Disease</b> <b>774X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>9-9-56</b> <b>9-10-56</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>19</b>				20g. (County) <b>19</b>		20h. (State) <b>19</b>	
21. I certify that I attended the deceased from <b>9-9</b> , 19 <b>56</b> , to <b>9-10</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9-10</b> , 19 <b>56</b> , and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, Bainbridge, Maryland</b> DATE SIGNED <b>11 Sep 1956</b>							
ACTUAL SIGNATURE <b>Albert J. Bise</b>				M.D. <b>USNH Bainbridge, Md</b>			
PHYSICIAN'S NAME (Type) <b>ALBERT J. BISESE</b>				U. S. Naval Hospital, Bainbridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11 Sep 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham</b>		22d. LOCATION (City, town, or county) (State) <b>Rising Sun (Rural) Cecil, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rea Patterson</b>				ADDRESS <b>Perryville, Maryland</b>		24a. REC'D BY REGISTRAR <b>10 Sep 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Shirley Kelly</b>							

2051232 XV2

SEP 17 1956

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09263

9255

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Cecil</u>		STATE <u>Maryland</u> COUNTY <u>Cecil</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Elkton</u>		LENGTH OF STAY (in this place) <u>1 day</u>		TOWN <u>Rural</u> <u>Route 4</u>		STREET ADDRESS (If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>							
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Leslie</u> (First) <u>C.</u> (Middle) <u>Pennock</u> (Last)		<b>4. DATE OF DEATH</b> (Month) <u>Sept</u> (Day) <u>6</u> (Year) <u>1956</u>					
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>March 25, 1892</u>	<b>9. AGE last birthday</b> <u>64</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>	<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>paper maker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Robert Pennock</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary R. Todd</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>217-09-1900</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Elizabeth Walker, R.D. 4 Elkton</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
151X IMMEDIATE CAUSE (A) <u>Carcinoma of stomach</u>						INTERVAL BETWEEN ONSET AND DEATH <u>.195-3</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <u></u> <u></u> <u></u> <u></u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>Sept 5, 1956</u> , to <u>Sept 6, 1956</u> , that I last saw the deceased alive on <u>Sept 5, 1956</u> , and that death occurred at <u>7:20 a.</u> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Infant Sprague</u> M.D.				<b>DATE SIGNED</b> <u>Sept 6, 1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Sept. 9, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Rosebank Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Calvert, Cecil Co. Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>4/7/56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>JR Sprague</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ralph E. Hickey</u>		<b>ADDRESS</b> <u>103 Stockwell St, Elkton, Md.</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BIRTH [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		MARITAL STATUS [Faint text]	
PREVIOUS ILLNESS [Faint text]		MEDICAL HISTORY [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	

RECEIVED  
 SEP 11 1956  
 BUREAU V. A.

This certificate is required by law to be filed with the State Department of Health within 24 hours of the death. It is the duty of the physician or other person having knowledge of the cause of death to fill out this certificate and to sign it. It is also the duty of the person having knowledge of the place of death to fill out this certificate and to sign it. The certificate must be filed with the State Department of Health within 24 hours of the death. It is the duty of the physician or other person having knowledge of the cause of death to fill out this certificate and to sign it. It is also the duty of the person having knowledge of the place of death to fill out this certificate and to sign it. The certificate must be filed with the State Department of Health within 24 hours of the death.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09264

9256

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Elkton</u>		<u>18 hours</u>		TOWN <u>Sassafras</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>				STREET ADDRESS (If rural give location) <u>Sassafras -Townsend Rd.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Raymond</u> <u>Ringgold</u>				<u>Sept</u> <u>30</u> <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 13 1912</u>	9. AGE last birthday <u>44</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building Labor</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13. FATHER'S NAME <u>Raymond Ringgold</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Christy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
331X IMMEDIATE CAUSE (A) <u>Cerebro-vascula accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ruptured intracranial vessel</u>				<u>18 hours</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension and generalized arteriosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 15</u> , 19 <u>56</u> to <u>Sept 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 30</u> , 19 <u>56</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wallace Oleschun</u> M.D.				ADDRESS (Street, city, town, state) <u>Cecil, Md</u>		DATE SIGNED <u>1 Oct 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Oct 6 1956</u>	NAME OF CEMETERY OR CREMATORY <u>John Wesley Cemetery</u>		LOCATION (City, town, or county) <u>Sassafras Md.</u>		(State)	
24. REC'D BY REGISTRAR <u>Oct 8 1956</u>	REGISTRAR'S SIGNATURE <u>F. R. Fryer</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Bellar</u>		ADDRESS <u>Millington Md.</u>			

11.



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BUREAU V.

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# DATA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9274 CERTIFICATE OF DEATH

Reg. Dist. No. 90

09265

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 3639 Veazey St., N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ERVIN Middle G. Last SCHWARZMANN		4. DATE OF DEATH Month September Day 4 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-89
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Schwarzmenn		14. MOTHER'S MAIDEN NAME Matilda (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobar, bilateral, unresolved 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4-5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 5, 1936, to September 4, 1956, and that death occurred at 4:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		DATE SIGNED 9-4-56	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-4-56	
22c. NAME OF CEMETERY OR CREMATORY Ivey Hill		22d. LOCATION (City, town, or county) (State) Alexandria, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Demaine Fun. Home		ADDRESS 520 So. Wash. St., Alexandria, Va.	
24a. REC'D BY REGISTRAR DATE Sept. 4, 1956		24b. REGISTRAR'S SIGNATURE Irene E. Wangherty	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. M.

SEP 6 1956

RECEIVED

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 FilmG202 9-13-56 et

09266

## 9257 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton		LENGTH OF STAY (in this place) 9 hr.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Chesapeake City			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital				STREET ADDRESS (If rural give location) George Street			
3. NAME OF DECEASED (Type or Print) (First) Margaret (Middle) (Last) Sheridan				4. DATE OF DEATH (Month) (Day) (Year) Sept. 6, 1956			
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 10/24/23	9. AGE last birthday 31 32 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sub Clerk Office U. S. Gov.			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Warren Sheridan				14. MOTHER'S MAIDEN NAME Helen Forwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-22-6702		17. INFORMANT & ADDRESS Chesapeake City Md. Helen F. Sheridan			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4438 IMMEDIATE CAUSE (A) Cerebro-Vascular Accident				INTERVAL BETWEEN ONSET AND DEATH 36 hours.			
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension				un known			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertensive Cardio-vascular Disease							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6 Sept, 1956, to 6 Sept, 1956, that I last saw the deceased alive on 6 Sept, 1956, and that death occurred at 5:15 PM, from the causes and on the date stated above.							
SIGNATURE Wallace Olmstead		M.D. Cecil, Md.		ADDRESS (Street, city, town, state) R. D. Chesapeake City, Md.		DATE SIGNED 8 Sept 56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9-9-1956		NAME OF CEMETERY OR CREMATORY Bethel Cemetery		LOCATION (City, town, or county) (State) R. D. Chesapeake City, Md.	
24. REC'D BY REGISTRAR DATE 9/10/56		REGISTRAR'S SIGNATURE H. F. Frazer		25. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pippin		ADDRESS 259 E. Main St. Elkton Md. W. G. Long	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. 8

SEP 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09267		
Item 20 Film G204 9-25-56 ams												
9275												
CERTIFICATE OF DEATH										Reg. Dist. No. 74		
1. PLACE OF DEATH a. COUNTY Cecil					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East					c. LENGTH OF STAY IN 1b Life							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Jesse Harvey Symers					4. DATE OF DEATH Sept 19th 1953							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26 - 1867		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter					10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Cecil County		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Joseph Symers					14. MOTHER'S MAIDEN NAME Emily Harper							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 717-12-3121		17. INFORMANT Miss Irene Symers - daughter					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 904.0 DUE TO General Arterio Sclerosis (b) Fractured pelvis (c) Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH Unknown Apr 13 - 56 Mo 1918		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell							
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. Apr. 6 1956					20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In his cellar		20f. (City or town) North East		(County) Cecil (State) Md	
21. I certify that I attended the deceased from April 13, 1956 to Sept 19th 1956 that I last saw the deceased alive on Sept 17, 1956, and that death occurred at 2:30 P. M. from the causes and on the date stated above.												
ACTUAL SIGNATURE V. H. McKnight					ADDRESS (Street, city or town, state) Elkton - Maryland DATE SIGNED							
PHYSICIAN'S NAME (Type) V. H. McKnight												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF Sept 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) North East Cecil Co. Md (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant					ADDRESS North East Maryland		24a. REC'D BY REGISTRAR DATE Sept 21 - 56		24b. REGISTRAR'S SIGNATURE Sarah E. Pethermal			

# CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. DATE OF DEATH <i>SEP 24 1956</i>	
3. PLACE OF DEATH <i>HOME</i>		4. COUNTY <i>ALBANY</i>	
5. CITY OR TOWN <i>ALBANY</i>		6. STATE <i>NEW YORK</i>	
7. SEX <i>MALE</i>		8. AGE <i>45</i>	
9. OCCUPATION <i>CLERK</i>		10. MARITAL STATUS <i>MARRIED</i>	
11. CAUSE OF DEATH <i>HEART DISEASE</i>		12. MANNER OF DEATH <i>NATURAL</i>	
13. SIGNATURE OF PHYSICIAN <i>J. J. SMITH</i>		14. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
15. SIGNATURE OF WITNESSES <i>J. J. SMITH</i>		16. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
17. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		18. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
19. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		20. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
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23. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		24. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
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91. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		92. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
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95. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		96. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
97. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		98. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
99. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		100. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	

BUREAU V. 3

SEP 24 1956

RECEIVED



9276

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		LENGTH OF STAY (in this place) <u>35</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		TOWN <u>Chesapeake City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.</u>				STREET ADDRESS (If rural give location) <u>R.F.D.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William Vincent Statkavige</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 29 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 30, 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>No Information</u>				14. MOTHER'S MAIDEN NAME <u>No Information</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>091-01-8745</u>		17. INFORMANT & ADDRESS <u>Chesapeake City</u> <u>Maria Statkavige R.F.D. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) <u>Carcinoma of sigmoid</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 29, 1956</u> to <u>Sept 29, 1956</u> , that I last saw the deceased alive on <u>Sept 29, 1956</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Henry Pippin</u>				ADDRESS (Street, city, town, state) <u>Chesapeake City Md</u>		DATE SIGNED <u>10/1/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-3-1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Roses Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chesapeake City Md.</u>	
24. REC'D BY REGISTRAR <u>10/4/56</u>		REGISTRAR'S SIGNATURE <u>H. Pippin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Pippin</u>		ADDRESS <u>Elkton Md.</u>	

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



9277

## CERTIFICATE OF DEATH

Reg. Dist. No.

52

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frenchtown Rd</b>		d. STREET ADDRESS <b>Frenchtown Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Thompson</b> Last		4. DATE OF DEATH Month <b>9</b> Day <b>12</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1871</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pattern Fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stove Foundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Martha Jane Gillespie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-8731</b>	
17. INFORMANT <b>Georgeanna Thompson, Perryville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260 Diabetes - Diabetic Gangrene left leg - amputated</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Sept 1955</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 7, 1956</b> to <b>Sept 12, 1956</b> that I last saw the deceased olive on <b>Sept 12, 1956</b> and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clarence I. Benson</b> M.D.		ADDRESS (Street, city or town, state) <b>Port Deposit, Md</b> DATE SIGNED <b>9/14/56</b>	
PHYSICIAN'S NAME (Type) <b>Clarence I. Benson, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-15-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 9-14-56</b>		24b. REGISTRAR'S SIGNATURE <b>Irene E. Daugherty</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 17 1956

BUREAU A. S.

RECEIVED